Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0543	A. BUILDING _____ B. WING _____	06/25/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING WELL A COMMUNITY CARE HOME	71 MAPLE STREET BRISTOL, VT 05443

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R100	Initial Comments: An unannounced onsited survey was conducted by the Division of Licensing and Protection beginning on 4/14/09 and ending on 6/25/09.	R100		
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to complete a full reassessment for a resident with a significant change in physical condition (Resident #1). Findings include: 1. Per record reviews on 4/14/09 and on 4/20/09, Resident #1 experienced a significant physical decline. Per interview with the facility Nurse and facility Administrator on the afternoon of 4/20/09, Resident #1 had experienced a severe physical decline to the point that Hospice services were initiated on 4/9/09. The Nurse confirmed that the last assessment for Resident #1 occurred "around 8/1/08" and that a significant change assessment had not been completed.	R136	Actions → Administrator met with house nurse & discussed in detail the assessment requirements & specifics of this deficiency! Changes → We now have a master calendar for annual reassessment, updated monthly Summary assessments and an understanding that a full reassessment is required whenever a resident has a change in physical or mental condition. Monitoring → Our Resident Care Coordinator works each week with the nurse to ensure timely reassessments	
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for	R145	Administrator checks in several times a month with House Nurse and Resident Care Coordinator ensuring compliance. BC Inspector 10-12-09	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/24/09

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R145	Continued From page 1 each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop a plan of care describing the care and services necessary for 1 applicable resident (Resident #1). Findings include: 1. Based on record review on 4/14/09, the care plan for Resident #1 did not include an update to indicate Hospice interventions initiated on 4/9/08. On the afternoon of 4/20/09 the facility Nurse confirmed that the current care plan had not been updated following a significant change in health status and did not contain the plan of care established by the Hospice program.	R145	Action → Administrator met with House nurse and discussed in detail the care plan requirements + Specifically this deficiency. In addition, ACHH+H has supplied copies of original Hospice interventions as well as current Hospice POC. House nurse has updated all resident care plans. As of 8/24/09 all resident care plans are current. Changes → Our Resident Care Coordinator (RCC) works weekly with the House Nurse (HN) to ensure care plans are updated as resident Status' changes ~~to ensure~~ Monitor → Administrator follows up several times a month with HN + RCC ensure compliance. POC ends 10.12.09	4/24/09
R148 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (5) Assure that residents' medications are reviewed periodically and that all resident medications have either a supporting medical diagnosis or problem; This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility nurse failed to assure that medications for 3 of 5 Residents (Resident #1 and Resident #2) had supporting diagnosis for all ordered medications. Findings include: 1. Based on record review on 4/14/09 and	~~Monitor~~ R148	Action → Administrator met with HN + RCC, reviewed in detail this requirement and Specifically this deficiency. Both HN + RCC have reviewed med orders + requested supporting material/diagnosis/problem from prescribing physicians.	4/28/09 8/15/09

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R148	Continued From page 2 4/20/09, the 4/09 Medication Administration Record (MAR) of Resident #1 had no reason listed for "Alprazolam / Zanax 0.125mg (milligram)1-2 tabs p. TID (3 times per day) as needed (PRN)". A new order was obtained for this resident on 4/16/09 stated "D/C (discontinue) Xanax scheduled and PRN". This order was replaced with "Haldol intensol 0.25mg TID and Haldol intensol 0.25mg Q(every) 2-4 hours PRN". Per interview on 4/20/09 at 3:40 PM the facility nurse confirmed that neither of these PRN orders contained a supporting diagnosis for administration as written. 2. Based on record review on 4/20/09, the 4/09 MAR of Resident #2 containing an order for "Robitussin CF cough syrup PRN" did not specify a reason for this medication. Per interview on 4/20/09 at 3:40 PM, the facility nurse confirmed that the order did not specify a reason to administer.	R148	Changes → Our Medication Management Coordinator (MMC) works weekly with HN to ensure Doctors' orders for medication also state Supporty medical diagnosis/ problem medication is prescribed for. Monitoring → Administrator follows up several times a month with HN, MMC & RCC ensuring compliance. RCC signed 10-12-09	10/12/09
R173 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h. (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel shall have access to the keys This REQUIREMENT is not met as evidenced by: Based upon observation and interview, the facility failed to assure that only authorized personnel	R173	Action → Administrator met with HN & advised/reviewed in detail this requirement and specifically this deficiency. 4/16/09 Administrator MMC met with employee in question, reviewed the requirement & Specifically this deficiency, stressed the seriousness of this situation within the context of a formal write up (See attached) 6/8/09	

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R173	Continued From page 3 have access to medication and / or medication compartment keys. Findings include: 1. Per observation on 4/14/09 at 12:01PM, the medication cabinet keys were in the door of the cabinet with staff preparing food in the kitchen area. Per interview with a staff member at 12:07 PM, it was confirmed that the medication keys were left in the cabinet lock and were removed at this time.	R173	Changes → At May Staff mtg HN+ MMC reviewed requirement + Specifically this deficiency and also proper procedures with med keys, Staff keeping med keys on your person at all times	5/20/09
R177 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (5) Narcotics and other controlled drugs must be kept in a locked cabinet. Narcotics must be accounted for on a daily basis. Other controlled drugs shall be accounted for on at least a weekly basis. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assure narcotics counts occur daily for all narcotics and weekly for all other controlled drugs in the facility. Findings include: 1. Per record review on 4/20/09, the facility failed to perform a daily count for narcotics contained in a closet on the second floor. Per interview on 4/20/09 at 1:30 PM, the facility Nurse and facility Administrator confirmed that a one month supply of narcotics are kept in the downstairs medication cabinet and that these narcotics and other controlled drugs are counted daily; however, both	R177	Monitor → Administrator follow up monthly with HN + MMC ensuring compliance. POC complete 10.12.09 Action → Administrator met with HN + MMC to review requirement + Specifically this deficiency. All med certified staff advised of this requirement, deficiency + details reviewed covering all narcotics counted daily / controlled drugs weekly.	monthly x 6 mos 4/28/09 7/9/09

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R177	Continued From page 4 agreed that a second supply of narcotics (overflow) is kept in the closet on the second floor and are counted by staff when first entering the facility, when removed for placement in the first floor medication cabinet, and when disposal is required. Daily and / or weekly counting of these narcotics and / or other controlled drugs is not performed as required.	R177	changes → MMC + HN coordinate daily + weekly counts Monitoring → Administrator follows up several times a month with MMC + HN ensuring compliance. RC agent 10.12.09	on going
R194 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.14 Restraints 5.14.a Mechanical restraints may be used only in an emergency to prevent injury to a resident or others and shall not be used as an on-going form of treatment. The use of a mechanical restraint shall constitute nursing care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure that mechanical restraints are used only in emergency situations for 1 applicable resident (Resident #1). Findings include: 1. Per observation on 4/14/09 at 11:50 AM, Resident #1 was sitting in an electric recliner chair, reaching over the right side arm of the chair, and calling out for help to rise. Per immediate interview with a staff member, it was confirmed that Resident #1 "is not allowed the control because s/he'll try to get up and then falls". A second staff member interviewed at 12:15 PM on 4/14/09 confirmed that the chair is reclined and the remote 'hidden' to prevent the resident from rising. Per record review, it was confirmed that no physician order nor care plan	R194	Action → Administrator met with HN, RCC + staff, reviewed requirement and specifically the deficiency. RCC has requested signed orders from primary care physician. 7/14/09 Changes → RCC and Administrator monitor daily/weekly for possible restraint violations. on going House nurse to review care plan upon receipt of doctors order	on going

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R194	Continued From page 5 was present to indicate this treatment for this resident.	R194	Monitor → Administrator & RCC following up daily/ monthly ensuring compliance. ongoing DOC appt 10.12.09 Action → Administrator reviewed this requirement with all staff & specifically the 7/30/09 delivery. Changes → There is now a second bulletin board in the kitchen 7/30/09 that all residents can easily access. All pertinent obligations of the RCH to residents are posted on this bulletin board 7/30/09 Monitor → Administrator follows up several times a month ongoing ensuring compliance. DOC appt 10-12-09	
R230 SS=F	VI. RESIDENTS' RIGHTS 6.18 The enumeration of residents' rights shall not be construed to limit, modify, abridge or reduce in any way any rights that a resident otherwise enjoys as a human being or citizen. A summary of the obligations of the residential care home to its residents shall be written in clear language, large print, given to residents on admission, and posted conspicuously in a public place in the home. Such notice shall also summarize the home's grievance procedure and directions for contacting the Ombudsman Program and Vermont Protection and Advocacy, Inc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the faciltiy failed to assure that a summary of the obligations of the residential care home is posted conspicuously in a public place in the home. Findings include: 1. Per observation on 4/14/09 and 4/20/09, the facility posted the obligations of the home to residents, the home's grievance procedure, and directions for contacting the Ombudsman Program and Vermont Protection and Advocacy Program on the landing (3-4 steps up) leading to the second floor administrative offices. Per interview with the Administrator on the afternoon of 4/14/09 it was confirmed that not all residents in the home could access this document.	R230		

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R281	Continued From page 6	R281		
R281 SS=D	IX. PHYSICAL PLANT 9.3 Toilet, Bathing and Lavatory Facilities 9.3.e Resident lavatories and toilets shall not be used as utility rooms. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to assure that resident lavatories and toilets shall not be used as utility rooms. Findings include: 1. Per observations on 4/14/09 and 4/20/09, the downstairs resident bathroom was used by staff as a utility room. Per interview on 4/20/09 at 4:15 PM, the Administrator confirmed that the downstairs bathroom (resident) functions as a utility room as well because there is no other water source available.	R281	action → Administrator reviewed this requirement + specifically this deficiency with all staff. 7/1/09 changes → All cleaning supplies, mops + brushes have been removed from the mop sink in the 7/1/09 bathroom. Bath + Kitchen renovations include a separate utility closet 2012+	
R302 SS=F	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented.	R302	Monit's → Administrator checks weekly ensuring compliance. (ongoing) RC grant 10.2.09 action → Administrator reviewed this requirement + specifically this deficiency with all staff 4/16/09	

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This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to perform routine fire drills for a yearly total of 6 drills (2 of which must be conducted during the night time hours of sleep) on all 3 shifts.
Findings include:

1. Per record review on 4/20/09, a total of 5 fire drills had occurred during the past year as follows:
3/23/09 at 2:00 PM,
3/13/09 at 4:00 PM,
10/20/08 at 5:00 PM,
4/15/08 at 10:00 AM, and
2/18/09 at 1:00 PM.
During interview on the afternoon onsite visit of 4/14/09, the Administrator confirmed that fire drills had not been completed on all 3 shifts as required.

Changes → We now have a designated Staff person document regular fire drills and other emergency protocols 4/25/09

We have Schedule at least 2 fire drills for each Shift with the 3rd Shift drills occurig first. 4/16/09 5/20/09 6/7/09

POC agreed 10.12.04

Monitorig → Administrator checks monthly ensurig compliance.

Ongoig